



# Mean Streets: Identifying and Responding to Urban Refugees' Risks of Gender-Based Violence

## Refugees with Disabilities



## Research. Rethink. Resolve.

The Women's Refugee Commission improves the lives and protects the rights of women, children and youth displaced by conflict and crisis. We research their needs, identify solutions and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

### Acknowledgments

This report is taken from a longer report produced by the Women's Refugee Commission, *Mean Streets: Identifying and Responding to Urban Refugees' Risks of Gender-Based Violence*. The full report, along with stand-alone sections on women; children and adolescents; LGBTI refugees; refugees engaged in sex work; and men and boys, including male survivors, is available at <http://wrc.ms/1KccsHt>.

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Cover photograph: An adolescent girl with intellectual disabilities from Syria shares her concerns and ideas through pictures at a consultation in Beirut. © WRC/Emma Pearce

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## Contents

Acronyms and Abbreviations	i
Introduction	1
The Urban Model: Challenges and Opportunities for Mitigating Urban GBV Risks and Strengthening Community-Based Protection	2
Refugees with Disabilities	3
Notes	17

## Acronyms and Abbreviations

CBO	Community-based organization
GBV	Gender-based violence
LGBTI	Lesbian, gay, bisexual, transgender and intersex
NGO	Nongovernmental organization
UNHCR	United Nations High Commissioner for Refugees
WRC	Women's Refugee Commission

## Introduction

An increasing majority (nearly 60 percent) of refugees live in cities, a figure that will continue to rise as camps become an option of last resort. This new reality necessitates a monumental shift in humanitarian response, requiring policy makers, donors, and practitioners to develop new programming that addresses the protection concerns of refugees in urban contexts.

Urban refugees face gender-based violence (GBV) risks as a result of multiple and complex unmet social, medical, and economic needs, as well as intersecting oppressions based on race, ethnicity, nationality, language, class, gender, sexual orientation, and disability. Misperceptions further contribute to discrimination toward refugees, which in turn heightens their vulnerability.

Throughout 2015, the Women's Refugee Commission (WRC) conducted research in urban settings, the first phase of a multi-year project to improve the humanitarian community's understanding of and response to GBV risks in urban contexts. Quito, Ecuador; Beirut, Lebanon; Kampala, Uganda; and Delhi, India, were chosen because they are host to diverse refugee populations, have different policy environments for refugees, and are at different stages of humanitarian response.

The project looked separately at the GBV risks of different urban refugee subpopulations: women; children and adolescents; lesbian, gay, bisexual, transgender, and intersex (LGBTI) individuals; persons with disabilities; and men and boys, including male survivors of sexual violence. Refugees engaged in sex work were added as a subpopulation, due to their invisibility and the heightened GBV risks they face.

For findings from the research and recommendations, read the full report at <http://wrc.ms/1KccsHt>.

## The Urban Model: Challenges and Opportunities for Mitigating Urban GBV Risks and Strengthening Community-Based Protection

Traditional humanitarian response – where UNHCR and its partners create a new infrastructure of services for refugees – is a poor fit for urban contexts. Instead of trying to transplant programs that have worked in camps to cities, programming must focus on promoting refugee integration into the host community. Doing this requires thinking differently across the board. Whereas humanitarian actors are used to working mostly with each other, in cities they must broker linkages with numerous other partners, public and private, across all sectors, and sometimes for the benefit of only one or two refugee subpopulations.

Protective peer networks must also become a cornerstone of urban protection. These peer networks can be among refugees, for instance, in the form of support groups hosted by UNHCR partners.

Yet protective peer networks can also exist, and need to be supported, between refugees and members of the host community. The important point is giving space for refugees to voice and cultivate the peer networks that are relevant for them, and offering them support – referrals, introductions, transportation costs, seed funding for a safe space – that will enable these peer networks to germinate.



## Refugees with Disabilities

*“In Kampala I have shifted over [moved to new housing] more than ten times because when I reach somewhere all the people who are renting nearby, they start to complain and they go to the landlord and say that if I remain here with my daughter who is like a monster, maybe the pregnant ladies nearby are going to give birth to babies who are also monsters, like my daughter... Where can I go again?”*

– Mother of a girl with a physical disability, discussing the difficulty of finding stable and safe housing in the city

### Previous Research on GBV among Refugees with Disabilities

This project seeks to expand on previous research conducted by the WRC on GBV against refugees with disabilities, addressing the ongoing gaps in evidence around effective strategies for GBV risk mitigation in urban settings.

Persons with disabilities, as defi by the Convention on the Rights of Persons with Disabilities, “include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”<sup>1</sup> Persons with disabilities are a heterogeneous group in terms of both impairment type and functional capacity. This diversity, overlaid onto other intersecting identities, like those related to age and gender, means that depending on their disability, individuals will encounter different GBV risks and barriers to inclusion in humanitarian response, including in GBV programming.

In 2008, the WRC embarked on cross-sectional research that examined the protection concerns of persons with disabilities in humanitarian settings, and released a report and a toolkit for practitioners. In Nepal, Thailand, and Ecuador, the field studies cited sexual violence, domestic abuse, and physical assault as protection risks facing refugee women with disabilities.<sup>2</sup>

More recent assessments conducted by the WRC with refugees and displaced persons in Bangladesh, Ethiopia, India (Delhi), Lebanon, Nepal, Philippines (Mindanao), Thailand, and Uganda found that violence was reported by both men and women with disabilities in all contexts. Women and girls with disabilities were most likely to report concerns about sexual violence, with concrete examples suggesting that those with intellectual and mental disabilities may be most at risk. Isolation, lack

of contact with community networks, and few independent living options also exposed both men and women with disabilities to different forms of violence inside the home.

Further, adolescents and young persons with disabilities were excluded from peer activities that could facilitate the development of vital social networks and enhance their protection from various forms of violence, including GBV.<sup>3</sup>

From 2012 to 2014, the WRC conducted a study into the sexual and reproductive health needs, risks, and capacities of refugees with disabilities living in Kenya, Nepal, and Uganda. This study identified that refugees with disabilities who are isolated in their homes, and those with intellectual disabilities, had reduced access to information about family planning, violence, and other sexual and reproductive health issues. Risks of sexual violence were highlighted across all three sites, with caregivers expressing concern about sexual violence against those with intellectual disabilities.<sup>4</sup>

In a separate project, the WRC and the International Rescue Committee conducted participatory action research on disability inclusion in GBV programming in humanitarian settings in Ethiopia, Burundi, Jordan, and Northern Caucasus in the Russian Federation. Findings identified that women with physical disabilities who are isolated in their homes in urban settings were being raped on a repeated and regular basis, often involving multiple perpetrators; and that women, men, girls, and boys with intellectual disabilities were particularly vulnerable to all forms of sexual violence, as well as emotional and physical abuse in these contexts.<sup>5</sup>

## **Methodology for Engaging Persons with Disabilities**

Building on findings from previous research, this project sought to document in more detail the factors that make persons with disabilities more vulnerable to GBV in urban settings; the gaps in services that are linked to GBV prevention and risk mitigation; and recommendations for humanitarian actors operating in urban settings to reduce risk of violence, abuse, and exploitation of refugees with disabilities.

In Beirut, the WRC conducted group discussions with refugees with intellectual disabilities and their caregivers. They were identified through the UNHCR ProGres database and community center partners, and invited to participate in the consultation process. Caregivers participated in group discussions and interviews. A concurrent activity was conducted with individuals with intellectual disabilities, using participatory methodologies, to collect information about their own concerns and perspectives.

In Kampala, the WRC targeted a fledgling association of refugees with disabilities for group discussions. This group was established in 2011, supported by the Refugee Law Project, and provides support to roughly 120 families in Kampala. The Association





identifies new arrivals and shares information about available services and assistance, including agencies that have dedicated disability officers and focal points. Representatives have further been identified for the various national origins and languages that are used by the diverse refugee community.<sup>6</sup> Most of the individuals consulted in these group discussions had physical disabilities or were caregivers of persons with intellectual and hearing disabilities.

In Quito, the WRC was unable to locate refugees with disabilities to engage in the project through our partners, highlighting a significant gap in inclusion in refugee programs in this context. We did, however, interview service providers and other key informants in all three sites to identify gaps and opportunities to strengthen disability inclusion for the purposes of GBV prevention and risk mitigation.

In addition to drawing from the experiences of refugees consulted in Beirut and Kampala during this project, this section of the report is also informed by consultations undertaken with women, men, adolescent girls, and adolescent boys with disabilities and their caregivers from other WRC projects, including research conducted in Bujumbura, Burundi; Kampala, Uganda; and Ramtha, Mafrag, and Irbid, Jordan.

The discussion below expands on this previous research, highlighting the following key GBV-related risks faced by urban refugees with disabilities and their caregivers. The section also explores good practices, notably around strengthening protective peer networks for refugees with disabilities and their caregivers, both through support groups and through building linkages with host community representative organizations of persons with disabilities (DPOs).

## Key GBV Risks

### *Risks related to stigma and discrimination*

Refugees with disabilities are stigmatized and discriminated against on the basis of their disability. This intersects with other types of discrimination they face due to their refugee status, nationality, ethnicity, religion, and, of course, gender.

The discrimination that women and girls with disabilities face gives rise to a host of GBV risks, including significant risks of emotional violence and sexual violence, both inside and outside their homes. Women with disabilities who are isolated in their homes are particularly at risk of sexual violence and rape, as are girls with intellectual disabilities. The stigma associated with being raped makes many woman and girls reluctant to report such violence, and many are also unable to report it because they have little interaction with people outside their immediate family or immediate environment.

*“People don’t want to share their experiences because they think it’s shameful or degrading, so they keep it all inside... The majority of the women [in the group] who have become disabled, they... were raped. Because they are considered a taboo, they feel shame in talking. They keep having those problems. We find it very really hard for them to get services.”*

– Male participant in a group discussion with the Association of Refugees with Disabilities in Kampala

Although we know that globally, women and girls are generally more at risk of sexual violence than men and boys, consultations with urban refugees with disabilities and their caregivers suggest that boys and men with intellectual disabilities are also targeted for sexual violence.

Adult men with disabilities, on the other hand, most often reported experiencing emotional violence and being denied employment as a result of their disability. This perpetuates a cycle of emotional violence at home and within their community, since they are unable to fulfill their assigned roles as “men” and are targeted for emotional violence as a result.

*“We have a lot of challenges in getting jobs. When they see physical appearance it’s very difficult to get a job. But he could be the father of children or a grandfather. So it affects the entire family.”*

– Man with a physical disability in Kampala

The rejection from employment on the basis of disability, combined with the added costs that households of persons with disabilities face due to frequent health visits and transportation needs, creates a ripple effect on the lives of their families. They struggle to find alternative sources of income necessary to survive in a city, and rely on income-generating activities that are often fraught with GBV risks of their own, from putting their children to work to engaging in sex work. Women with disabilities in a variety of urban contexts have also reported that poverty and a lack of income-generating opportunities increases the likelihood that they may engage in sex work and/or exploitative relationships.<sup>7</sup>

*“They are discriminated against in all activities – you don’t have any value. When men propose sex to her, she accepts because she needs money to provide food for to her children.”*

– Participant in group discussion with women survivors with disabilities and female caregivers in Bujumbura<sup>8</sup>



Boys and young men with disabilities are subject to emotional violence along the same lines. They are often not able to marry, or work, which is perceived by families and community members as an indictment on their masculinity, which is communicated through verbal and physical abuse. If you are a young man with a disability, “there’s no way you can be acceptable.”<sup>9</sup>

*“Because a boy is disabled...he cannot really contribute anything to the family. That’s how they are judging him...And then in the family you find that this one is living without any hope.”*

– Man with a disability in Kampala

### **GBV risks related to a lack of stable and safe housing**

In an urban context, where refugees are largely responsible for finding their own housing, persons with disabilities encounter unique barriers to finding adequate shelter. Landlords refuse to rent to them, or evict them abruptly not only on grounds of stigma and discrimination, but also, in some locations, stigmatizing superstitions around disability. In Kampala, for instance, where many Ugandans believe that disability is contagious, or a bad omen, landlords refuse to rent to refugees with disabilities, or to refugees who have a family members with a disability. These families are also forced to move continually, as neighbors agitate and mobilize for their eviction.

*“My kid has epilepsy...people think it’s contagious. Others run away when he’s having an episode...Even the landlord is against me, thinks it’s a bad sickness, wants to kick us out because of it.”*

– Father in Kampala

In Lebanon, persons with disabilities and their caregivers have spoken of similar risks related to their housing, which instead stem from tension with their neighbors and landlords over noise that individuals with disabilities sometimes make while in their home. In these settings, multiple families may be sharing a single apartment or even a room in close proximity to neighbors. This factor, combined with the stress of displacement, can affect the behaviors of some individuals with disabilities.<sup>10</sup>

*“In custom here they say if a woman who is pregnant sees someone who [has a physical disability], then she’ll give birth to someone like that. So when her mom wants a place to rent they say that can’t give her a place to rent. Even neighbors don’t want her to live nearby.”*

– Refugee woman in Kampala discussing housing discrimination for persons with disabilities

Similarly in Lebanon, rented accommodation is largely inaccessible to persons with physical disabilities, increasing their isolation and reducing their access to services and programs. Caregivers also reported that the lack of space and overcrowding of apartments present risks for the safety and dignity of individuals with disabilities, particularly women and girls with disabilities.

*“They can’t move, they are always locked up and can’t even do basic hygiene.”*

– Caregiver of a young woman with intellectual disabilities, Beirut

Ultimately, in urban contexts, persons with disabilities and their families have less control over where they live, and in what conditions, and their families have fewer opportunities to build relationships with neighbors and develop the social networks that are central to community-based protection.

### ***GBV risks related to isolation***

The lack of stable housing contributes to isolation, since families are unable to establish social ties with neighbors or CBOs near where they live.

Persons with disabilities and their families experience isolation within their communities and within their homes in urban contexts – this disproportionately affects women, as families perceive them to be at greater risk of violence, abuse, and exploitation in the community. Group discussions with caregivers, particularly with mothers, highlighted that there is a fear of sexual violence and exploitation against girls and women with intellectual disabilities living in Beirut. They perceive that all locations outside the home pose a risk to women and girls with intellectual disabilities, and as such stay “locked up in the house.” They described how women and girls with disabilities need to be accompanied at all times, and that they are very cautious about which organizations and activities they allow them to attend. As a result, women and girls with intellectual disabilities spend most of the day inside their home, assisting with housework or watching television and listening to music. As one caregiver described it: “When there is minimal social communication, there is minimal chance of violence.”<sup>11</sup>

*“I am afraid of sending her alone and that someone will sexually exploit her. Maybe someone will hurt her or kidnap her...”*

– Mother of a girl with an intellectual disability, Beirut

While caregivers were less concerned about GBV against boys and men with intellectual disabilities, who reported more freedom of movement in the Lebanese community, they acknowledged that they are equally isolated from age-appropriate peer networks,



and as such spend most of their day interacting with children.

Transportation challenges unique to urban contexts also contribute to this isolation, preventing persons with disabilities from accessing services, programs, and activities. Refugees with physical disabilities, for instance, report having great difficulty taking even the most ubiquitous and affordable means of public transportation; getting to a bus stop can be extremely difficult, and can put a service or participation in a peer activity out of reach. Added costs and logistical challenges relating to transportation have been documented to reduce access for GBV survivors with disabilities to case management and medical care in other urban settings, such as Bujumbura.<sup>12</sup>

*“There is no transport, so even if you know where services are, you still can’t get there.”*

– Participant in group discussion with women with disabilities and female caregivers, Bujumbura<sup>13</sup>

Female caregivers in Beirut also reported that time constraints and other responsibilities in the home reduced their capacity to assist persons with disabilities to attend activities outside the home, including refugee programs being run in the community centers. This reduced their access to information about programs and services, including information about GBV services.

When someone with a disability requires full-time care inside the home, it can also be difficult if not impossible for their caregiver, often a female family member, to attend services or peer support meetings. Hence, isolation not only affects the individual with a disability, but also other women and girls in the family who may also be excluded from activities, reducing their access to information and structured support.

### ***GBV risks related to the loss of protective networks***

Refugees with disabilities face unique risks resulting from the breakdown of protective networks that happens with displacement; these networks are often harder to rebuild in an urban context. Caregivers in Beirut described how displacement has disrupted vital community networks – they no longer know their neighbors, and as such don’t feel that is safe to let persons with intellectual disabilities, particularly women and girls, move around the community on their own. The loss of protective networks not only increases risk of violence outside the home, but also inside the home for persons with intellectual disabilities, as families have less support for caregiving: “Parents are over-exceeded in capacity and stressed – they need NGOs to take them out. Behaviors at home between family members are not good (because of the stress).”<sup>14</sup>

Caregivers in Kampala also reported a lack of adequate emotional and technical sup-

port for the work they do. This increases persons with disabilities' perceived – and actual – risk of abandonment and institutionalization. As one mother in Kampala expressed, she simply does not have the physical strength to care for her son, who requires assistance going to the toilet. She resorted to institutionalization: “I went to beg for help to take care of him” – even though she recognizes that, psychologically, this is harmful to him, “but he doesn't know that I can't take care of him at home.”

### **GBV risks related to service provision**

**Discrimination in GBV service provision – both prevention and response.** Refugees with disabilities in Kampala encounter discrimination, emotional violence, and verbal abuse when trying to access services. In consultations, they shared that they do not feel they are treated with dignity and respect when they go in for basic assistance, such as healthcare referrals, or when they go in for case management services, including to report incidents of rape and other forms of GBV.

*“This recommendation is just to tell those officers [NGO staff] not to take away the little hope they have. If I tell you, ‘I've been raped’, don't tell me ‘So what, you've been raped!’”*

– Woman representative from the Association of Refugees with Disabilities in Kampala

Access to good quality survivor-centered case management in health facilities may be a challenge for all GBV survivors, with one key informant expressing: “[The health clinic] is very crowded. I'm wondering how a raped, stigmatized woman with a disability walks in there. Maybe the man who raped her is there. Then she's supposed to sit in a chair and wait in line all day? With the same people coming in for malaria care? For education?”

Humanitarian actors, families, and communities across all countries tend to prioritize the disability-related needs of persons with disabilities, often failing to respond to other factors that may have a greater impact on GBV risk and protection. These factors might include a lack of peer support networks, children being out of school, living in substandard shelter, caregivers needing added assistance, or maybe just being a single woman with disabilities, which require a more comprehensive and holistic protection assessment and referral to a variety of other non-health-related services.

*“Service providers neglect persons with disabilities, they assume they cannot go [to activities]. They assume that a physical disability also means [our] brain is not working.”*

– Man with a physical disability, Beirut



Refugee service providers in nearly all locations reported that they lack the skills and capacities to better serve and engage persons with disabilities. They assumed that acquiring these skills and capacities would require many resources, including additional manpower and financial resources, so as to provide adequate health-related care to persons with disabilities. Wider WRC research, however, has highlighted that attitudes of staff and partners can be both the most significant barrier and the most significant facilitator to inclusion in GBV programs, with small, inexpensive changes making the biggest difference to participation of persons with disabilities.<sup>15</sup>

***Limited linkages to host country DPOs.*** Mainstream humanitarian partner organizations do not have regular contact with host country DPOs with which they could share information, or to which they refer refugees with disabilities for peer support. Many of the linkages that do exist between humanitarian actors and organizations with expertise around disabilities are focused solely on the medical and health response, such as the procurement of aids and devices for persons with disabilities. Indeed, in one city, a refugee service provider shared that its main priority for serving persons with disabilities is to help them obtain a special identification card that affirms their eligibility to receive a public subsidy for persons with disabilities; beyond that, they do not have disability inclusion or protection strategies in place.

There are, however, some positive examples of host country DPOs reaching out to refugees with disabilities, albeit on a small scale, and in turn strengthening their protective peer networks in urban contexts. (See section below on Good Practices.) It is important to note that host country DPOs may not be familiar with humanitarian principles and protection mainstreaming. One key informant from a DPO said that community members expressed dissatisfaction when they tried to deliver materials only to refugees with disabilities, perhaps demonstrating a lack of community engagement in planning, which could in turn expose individuals with disabilities to added risks in their community. Host country DPOs consulted throughout this project also acknowledged that they need further capacity development to fully recognize and respond to age and gender issues across their activities.

Gaps in community-based protection approaches. In most urban locations there is a gap in both community outreach and support. This has particular implications for persons with disabilities who are isolated in their homes and/or those who do

Children with disabilities are often excluded from youth programming generally. A father of a seven-year old girl with a disability in Kampala said that his daughter had never been invited to participate in International Children's Day celebrations at a local refugee service provider, or similar activities.

not feel safe to leave their homes. This increases the risk of GBV both within and outside of the home; as individuals with disabilities and their caregivers do not have the same access to information about available services, they are more likely to be targeted by perpetrators and less likely to get adequate support. Home visits are essential, as they are often the only occasions where individuals with severe physical disabilities whose mobility is restricted and individuals with intellectual disabilities have direct contact with service providers.

A lack of family-based care and support for individuals with more severe disability and a lack of respite for caregivers increase the likelihood of institutionalization, either through “boarding schools” and “mental hospitals,” separating them from their families and communities. Another primary motivator for sending family members with disabilities to institutions may be linking them up with a particular service, such as enabling their access to a specialized health or education facility for persons with disabilities. This is the case in Kampala, for instance, where parents of children with disabilities reported sending their children to state-sponsored boarding schools for the sole purpose of ensuring their children have access to an education, as inclusive education was not available. Global research on violence against persons with disabilities, however, has demonstrated that individuals who are institutionalized are at a higher risk of sexual abuse than those living in the community,<sup>16</sup> making the link between caregiver support, protective networks, and GBV a critical risk factor for refugees in urban settings.

## Good Practices

***Support group for refugees with disabilities and caregivers.*** Support groups that are run by, and for, persons with disabilities can become an integral part of their protective peer networks. Refugees with disabilities and caregivers in Kampala, for instance, have formed a support group that serves a variety of functions that they themselves prioritize. The group is called the Association of Refugees with Disabilities in Kampala. They started the group on their own, but now get referrals and support, such as a safe space to hold their meetings, from refugee service providers. One provider in particular, the Refugee Law Project, has been and continues to be their main supporter.

*“A reason we formed this association of people living with disabilities is it’s a way of comforting one another: giving support and sharing experiences.”*

– Member of Kampala support group, Association of Refugees with Disabilities





*“In the association we are a family, we are not really a group. I’d like to tell you that here we have different tribes, different nationalities. We came from different places: Congolese, Rwandese, Burundian, Sudanese.”*

– Member of Kampala support group, Association of Refugees with Disabilities

Identifying home visits as a foundational piece of their peer support and protection, members of the group spoke of their desire to be able to conduct these visits themselves, to check in on each other and those who are isolated in their homes. It is also an important part of affirmative outreach to persons with disabilities and their caregivers who feel too stigmatized to ask for support from service providers, or seek out peers. Yet the group was only able to conduct home visits once, during a one-week period, with the help of a small grant they received from a refugee service provider to hire a vehicle and a driver that enabled them to make the visits. They lack the financial resources to do it again, let alone to make it a regular activity.

***Linkages with host community organizations of persons with disabilities.*** While humanitarian actors have limited contact with host community DPOs, there are some positive examples of these organizations reaching out to refugees with disabilities, albeit on a small scale, and in turn strengthening their protective peer networks in urban contexts. This has proven effective in reaching particularly marginalized groups within the disability community, such as albinos, women and girls with disabilities, and those with intellectual disabilities.

The Lebanese Association for Self-Advocacy was established to ensure the voices of persons with intellectual disabilities are heard and all their rights respected. They have recently started self-advocacy training for refugees with intellectual disabilities in Lebanon, working with these individuals and their caregivers to explore topics such as expressing emotions and making decisions. These sessions bring together refugees with intellectual disabilities and Lebanese with intellectual disabilities and their caregivers, highlighting the things that they have in common and strengthening peer support through this shared identity.

In Kampala, the National Union of Women with Disabilities of Uganda (NUWODU) reached out to refugee women and girls with disabilities to identify their concerns and recommendations, and used this information to advocate for inclusion with other DPOs, humanitarian agencies, and donors at national, regional, and global levels.<sup>17</sup> They conduct “afternoon teas” each month at a different member’s home, inviting refugee women and girls with disabilities, so they can meet new people and get to know the safe places in Kampala.

*“I went and testified in church about this miracle that happened to make us meet with other women with disabilities in Africa and other visitors and how we were treated during the workshop. This has been my achievement in 2015, and it will always be [part of] my story. I want to thank NUWODU for searching for refugee women with disabilities.”*

– Refugee woman with disabilities living in Kampala<sup>18</sup>

***Inclusive community-based protection.*** UNHCR and its partners in Lebanon have continued to expand community-based protection mechanisms across the country. Networks of volunteers, local community representatives, and partners help link individuals with protection concerns to relevant service providers, and community and social development centers act as base for information and support to refugees. Some 329 community self-managed structures have now been established in collective sites and community centers.<sup>19</sup> Persons with disabilities are being recruited as refugee outreach volunteers and are represented in these management structures. Refugee outreach volunteers have demonstrated that with appropriate support and capacity development, they can be a valuable resource to vulnerable and isolated individuals and families in urban and non-camp contexts.

*“They will feel like they don’t have one disability, but rather many disabilities....I can provide support, communicate and encourage them. I can sensitize the family, but I understand that in some cases, when there is violence, I must refer....The community should not isolate persons with disabilities – they all have a role.”*

– Refugee Outreach Volunteer with a disability from Tripoli<sup>20</sup>

## **Recommendations for Mitigating GBV Risks Faced by Refugees with Disabilities**

- **Address discrimination by service providers.** Stigma and discrimination relating to disability – and fear of interacting with someone who is “different” – is ingrained in society, and will inevitably affect the work of humanitarian actors. Mentoring staff to reflect on their own attitudes relating to disability,<sup>21</sup> as well as to highlight successes in their interactions with persons with disabilities,<sup>22</sup> can have a greater impact on practice and preventing discrimination.
- **Support in finding safe, long-term shelter.** Recognizing the prevalence of housing discrimination on the basis of disability and heightened GBV risks associated with a lack of stable housing, humanitarian response must include targeted, proactive



support for refugees with disabilities and their families in finding adequate long-term housing. This needs to consider the specific needs of individuals who require more space because they are lying down most of the day, or because they may become agitated and distressed from too much noise.

- **Strengthen family-based care support and inclusive education.** Given growing evidence of the risk of violence faced by persons with disabilities in institutions around the world, it is critical that humanitarian actors strengthen community-based programs and the inclusion of persons with disabilities, wherever possible avoiding separation from their families and communities. To the extent that humanitarian actors provide referrals or support – including financial subsidies – for refugees to attend these institutions, protection monitoring mechanisms are crucial to ensuring that these institutions are safe places, and that sending persons there does not increase their exposure to GBV risks.
- **Support host community DPOs to expand and include refugees with disabilities.** Host community DPOs, particularly those focused on marginalized groups, which are often fledgling associations, cannot expand to include refugees without both financial and technical support. They should remain aligned with their wider mission, which is most commonly advocating to their governments on legislation, policies, and programs, but can also advocate for refugees with disabilities to have the same access to local services. DPOs may need training and mentoring on both gender and protection mainstreaming, which can be conducted by mainstream humanitarian actors.
- **Strengthen the representation of refugees with disabilities in community-based protection mechanisms.** Support refugees with disabilities and their caregivers in creating and maintaining their own support groups and pursuing the activities they identify as most likely to mitigate their GBV risks and strengthen their protective networks (e.g., trainings, workshops with DPOs, livelihood initiatives, home visits). Encourage them to reflect on the gender balance in these groups, and how persons with different types of disabilities are going to be reached and included in activities. Provide a budget for transportation or link this group to a livelihoods project.

As demonstrated in Kampala, these groups can also be a valuable resource to humanitarian actors, with information about the concerns of persons with disabilities and suggestions for change. Establish a regular meeting with these groups – this will help them to better understand the opportunities, as well as the limitations, and shape their recommendations accordingly.

*“Advocate for at least one meeting per year of the representatives of UNHCR with a group of refugees [with disabilities]”*

– Association of Refugees with Disabilities in Kampala

Lastly, set targets for the proportion of volunteers, refugee staff and committee members who will be persons with disabilities and their caregivers. A representative target would be 15 percent. This will encourage staff and partner to reach out, identify, and invite persons with disabilities.

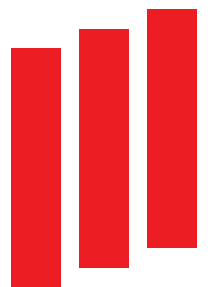


## Notes

1. Convention on the Rights of Persons with Disabilities, Art. 1, <http://www.un.org/disabilities/convention/conventionfull.shtml>
2. WRC, Disabilities among Refugees and Conflict-affected Populations (2008).
3. WRC, Disability inclusion: Translating policy into practice in humanitarian action (2014)
4. WRC, Sexual and reproductive health and disability: Examining the needs, risks and capacities of refugees with disabilities in Kenya, Nepal and Uganda (2015).
5. WRC and IRC, "I see that it is possible": Building capacity for disability inclusion in gender-based violence programming in humanitarian settings (2015).
6. WRC, "We have a right to love": The intersection of sexual and reproductive health and disability for urban refugees in Kampala, Uganda (2014).
7. WRC and IRC, "I see that it is possible": Building capacity for disability inclusion in gender-based violence programming in humanitarian settings (2015).
8. Ibid.
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21. See "Activity 1: Where do we stand?" in the Training Module for GBV Practitioners in Humanitarian Settings. This can be adapted for different groups and different topics, and is also available in Arabic. <https://womensrefugeecommission.org/component/zdocs/document/download/1166>
22. See the Reflection Tool for GBV Practitioners. This can be adapted for different groups and topics, and is also available in Arabic. <https://womensrefugeecommission.org/component/zdocs/document/download/1159>



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